FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06184 — 06180

1. DECEASED-NAME (Type or Print): First BERNARD Middle CASMIR Last BARANOWSKI
2a. DATE KNOWN OF DEATH ☑ ESTIMATED ☐: Month APRIL Day 6 Year 19 69
2b. HOUR 9:10 AM
3. SEX: M
4. RACE: W
5. DATE OF BIRTH: APR 23 1924
6. AGE (In years last birthday): 44 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
2c. DATE PRONOUNCED DEAD: Month APRIL Day 6 Year 19 69
2d. HOUR 9:10 AM
7a. BIRTHPLACE (State or Foreign country): BALTIMORE
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: WORCESTER Md.
10. CITY OR TOWN OF DEATH: Ocean City, Md
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 309 Baltimore Drive
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): POLICE OFFICER
12b. KIND OF BUSINESS OR INDUSTRY: Police
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md
13b. COUNTY: —
13c. CITY OR TOWN: BALTIMORE
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 3507 JUNEWAY
14. FATHER'S NAME First FRANK Middle Last BARANOWSKI
15. MOTHER'S MAIDEN NAME First MARY Middle KARLA Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): WW II
16b. SOCIAL SECURITY NO.: 212-20-0411
17. INFORMANT: MRS ANNA BARANOWSKI ADDRESS: 3507 JUNEWAY BALTIMORE, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY Occlusion Acute — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 HOURS
DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD with CORONARY SCLEROSIS — ?
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): F. J. TOWNSEND, JR M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
ADDRESS (Street or R.F.D., town or county): Md.
22b. DATE SIGNED: Apr 6, 1969.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4/10/69
23c. NAME OF CEMETERY OR CREMATORY: Baltimore, National
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland
24. FUNERAL DIRECTOR ADDRESS: Leonard J Ruck Inc, Baltimore, Maryland
25a. REC'D BY REGISTRAR DATE: APR 8 1969
25b. REGISTRAR'S SIGNATURE:

VR A15ME (5) 10M REV. 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06185

CERTIFICATE OF DEATH

06181

1. PLACE OF DEATH
   a. COUNTY: Worcester - Whaleysville — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Whaleysville, Maryland
   c. LENGTH OF STAY IN 1b: life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleysville, Maryland
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Josephine; Middle:; Last: Bunting

4. DATE OF DEATH: Month: April; Day: 30; Year: 1969

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: June 12, 1884

9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months: ~~10~~; Days: ~~18~~ IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland Worcester-Whaleysville

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lybrand Hudson

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Mumford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 222-22-8461-A

17. INFORMANT Address: Catherine Hall, Whaleysville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Hypertension
DUE TO (c): myocarditis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4310

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/1/67, 19___, to 4-30, 1969 that (I) (we) last saw the deceased alive on 4/26 1969, and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Clifford E. Schott M.D.

22d. ADDRESS: Berlin, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 3, 1969

23c. NAME OF CEMETERY OR CREMATORY: Red Men's

23d. LOCATION (City, town or county) (State): Selbyville Delaware

24. FUNERAL DIRECTOR: Richard T. Watson

ADDRESS: Selbyville, Del.

25a. REC'D BY REGISTRAR DATE: MAY 5 1969

25b. REGISTRAR'S SIGNATURE:

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06186 — 06182

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: ARVILLE	Middle: JAMES	Last: DUNCAN	2a. DATE OF DEATH: Month April Day 5 Year 1969	2b. HOUR: 12:05 P.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Jan. 13, 1900	6. AGE (In years last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: WORCESTER Md.		
10. CITY OR TOWN OF DEATH: Pocomoke City	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 209 Sixth Street	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Dealer	12b. KIND OF BUSINESS OR INDUSTRY: Automobile		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Pocomoke	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 209 Sixth Street	
14. FATHER'S NAME First: William	Middle: B.	Last: Duncan	15. MOTHER'S MAIDEN NAME First: Florence	Middle: Olivia	Last: Taylor
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no	(If yes give war or dates of service): --	16b. SOCIAL SECURITY NO.: 215-26-5379	17. INFORMANT: Mrs Ethel L. Duncan, Pocomoke, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Metastatic Cancer.	
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO, OR AS A CONSEQUENCE OF (b)	Carcinoma of Colon.	2 years.
DUE TO, OR AS A CONSEQUENCE OF (c)		

1538

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): none.

19a. DATE OF OPERATION: April 1967	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca of Colon.	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** thot (I) (~~this hospitol~~) ottended the deceased from 1967, 19____, to ____, 19____, thot (I) (we) lost sow the deceased olive on ~~the~~ April, 19 69, and thot in (my) (our) opinion deoth occurred on the dote and hour ond from the couses stated above, (I) (~~saw~~) (~~did~~) (did not) view the body ofter death.

22b. SIGNATURE: Joseph C. Fitzgerald	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: April 5, 1969	
22d. PHYSICIAN'S NAME (Type): Joseph C. Fitzgerald, M.D.	22e. ADDRESS: Medical Center, Salisbury, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4-7-1969	23c. NAME OF CEMETERY OR CREMATORY: First Baptist	23d. LOCATION (City or Town) (County) (State): Pocomoke City-Wor.-Md.	
24. FUNERAL DIRECTOR: Robert H. Watson	ADDRESS: Pocomoke City, Md.	25a. REC'D BY REGISTRAR DATE: APR 10 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

Robert H. Watson

VR A15 (4) 30M REV. 1-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06187

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06183

1. **PLACE OF DEATH**
   a. COUNTY: Worcester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
   c. LENGTH OF STAY IN 1b: 1 day
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
   d. STREET ADDRESS: Box 87
   e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Calvin — Middle: Ernest — Last: Fisher

4. **DATE OF DEATH**: Month: 4 — Day: 7 — Year: 1969

5. SEX: M

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-23-64

9. AGE (In years last birthday): 4 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Berlin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eddie Holland

14. MOTHER'S MAIDEN NAME: Annabel Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Annabel Fisher — Address: Box 87, Newark Md.

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Severe head trauma and hemorrhage
DUE TO (b): Avulsion of soft tissues from neck
DUE TO (c): chest and both hands
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 814.7
INTERVAL BETWEEN ONSET AND DEATH: 30 seconds

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Hit by truck on Market Street in Snow Hill

20c. TIME OF INJURY, Month, Day, Year, Hour a.m. p.m.: 12 noon April 7 1969

20d. INJURY OCCURRED While at work ☐ Not While at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town) (County) (State): Snow Hill, Worcester, Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Lloyd O. Long M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

EXAMINER'S NAME (Type): Lloyd O. Long, M. D., 104 Bay Street, Snow Hill, Maryland Worcester Co.

22. DATE SIGNED: April 10 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-10-69

23c. NAME OF CEMETERY OR CREMATORY: Williams A.M.E.

23d. LOCATION (City or Town) (County) (State): Newark Worc. Md.

24. FUNERAL DIRECTOR: Loretta B. Jolley — ADDRESS: Jersey Rd. Rt 2 Salisbury Md.

25a. REC'D BY REGISTRAR DATE: APR 14 1969

25b. REGISTRAR'S SIGNATURE: R Charles Judge

VR A15ME (5)
6M 1/67

7 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any deloy is necessory, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Exominer's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used os o burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremotion, or removol, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06188 06184

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First	Middle	Last
	WALTER	ERIC	GOERING

2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ — Month: 4 Day: 17 Year: 1969 — 2b. HOUR: 6:10 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	10-5-1904	64 YRS.		

2c. DATE PRONOUNCED DEAD — Month: 4 Day: 17 Year: 1969 — 2d. HOUR: 8:30 AM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Germany	U.S.A.		WORCESTER Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Pocomoke City	Rt. 13 - Holiday Inn	Civil Engineer	Building

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Wisconsin	Milwaukee	Milwaukee	YES ☒ NO ☐	2851 N. 78th Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Henry	--	Goering	-unk-		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	WW 2	- unk -	Mrs Walter Goering,	Milwaukee, Wis.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Heart Disease — 3 or 4 years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At hame, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I taak charge of the remains described abave, held an Autapsy ☐, Inspectian ☑, Inquiry ☑, and in my opinian death resulted fram: Natural causes ☑, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Lloyd O. Long M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

22b. DATE SIGNED April 17, 1969

EXAMINER'S NAME (Type) Lloyd O. Long, M.D.

ADDRESS (Street, city, town, or county) Snow Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Removal	4-18-1969	Wisconsin Memorial	Brookfield, Wisconsin

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert H. Watson (Robert H. Watson)	Pocomoke City, Md.	APR 21 1969	Charles Judge

VR A15ME (5)
10M REV. 1/68

1

FOR STATE HEALTH DEPT.

06189

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#2a, FilmG412 5/1[illegible]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07691

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH / ESTIMATED	Month	Day	Year	2b. HOUR
Edward	V.	Holland	sex	April	30	1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month / Day / Year	2d. HOUR
Male	Negro	Mar. 31, 1890	79 YRS.			May 1 1969	M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Md.	U.S.A.	WIDOWED ☒	Worcester Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Snow Hill	Rural - Snow Hill	Laborer	Farm

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Worcester	Snow Hill	YES ☐ NO ☒	R.F.D. I Bx. 182

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Irving		Holland	Mary		?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	None	Lola Hudson	Snow Hill, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ACUTE PULMONARY EDEMA	HOURS
DUE TO, OR AS A CONSEQUENCE OF (b)	CHRONIC MYOCARDIAL INSUFFICIENCY	2 YRS
DUE TO, OR AS A CONSEQUENCE OF (c)	ARTERIO SCLEROTIC HEART DISEASE	?

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert C. Lamar M.D.

EXAMINER'S NAME (Type): ROBERT C. LAMAR

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: MAY 4, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5-5-69	Home Beneficial Cem.	Stockton Wor Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Daniel Lee	New Church, Va.	MAY 7 1969	Charles Judge

VR A15ME (5)
10M REV. 1/68

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forworded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, priar to burial, cremation, or removol, and in any event within 72 hours after death.

1

06190

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06185

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Jerry		Palmer	Apr. 4 1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Negro	Apr. 14, 1880	88 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Penn.	U.S.A.		Worcester Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Pocomoke	705 S. - 4th St.	Laborer	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Md.	Worcester	Pocomoke		705 S. - 4th St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Unknown			Unknown		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or Unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		Edith Palmer	705 S. 4th St. Pocomoke, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease — 7 years
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
c. Hypertension r. Generalized Arteriosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from May 16, 1966, to Apr. 4, 1969, that (I) ~~(we)~~ last saw the deceased alive on Apr. 4 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Charles W. Trader, M.D.	M.D.				4-7-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Charles W. Trader, M.D.	302 Market St., Pocomoke, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	4-9-69	Halls Hill Cem.	Pocomoke	Wor.	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Samuel Savage	New Church, Va.	APR 11 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06191

CERTIFICATE OF DEATH

06186

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): BERLIN NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: MAIN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First EVA — Middle BELLE — Last PENNEWELL

4. DATE OF DEATH: Month APR. — Day 16 — Year 1969

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: OCT. 5 1879

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): BERLIN MD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ROBERT GRAY

14. MOTHER'S MAIDEN NAME: SALLIE (CAREY)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. JAY McCROSSON LAUREL SPRINGS N.J.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocarditis,
DUE TO (b): Chronic Myocarditis,
DUE TO (c): Cerebra vascular disease
428X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this haspital) attended the deceased from 1-15- , 1969 to 4-16- , 1969, that (I) (we) last saw the deceased alive on 4-14 1969, and that death occurred at 12 P.M. from causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Clifford E. Schott MD

22d. ADDRESS: Berlin, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/19/69

23c. NAME OF CEMETERY OR ~~CREMATORY~~: EVERGREEN

23d. LOCATION (City or Town) (County) (State): BERLIN WOR MD

24. FUNERAL DIRECTOR: Anna A. Burbage — ADDRESS: Berlin Md

25a. REC'D BY REGISTRAR DATE: APR 21 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06192

06187

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Jane	Middle: Pearl	Last: Sherman	2a. DATE OF DEATH Month: April	Day: 12	Year: 1969	2b. HOUR: 5 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: June 14, 1889	6. AGE (In years last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Pa.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Worcester Md.				
10. CITY OR TOWN OF DEATH: Snow Hill	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 106 Powell St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Snow Hill	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 106 Powell St.			
14. FATHER'S NAME First: William	Middle	Last: Brown	15. MOTHER'S MAIDEN NAME First: Sara	Middle	Last: Clark		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No	(If yes give war or dates of service): -----	16b. SOCIAL SECURITY NO.: 214267315D	17. INFORMANT: Mrs. Carol E. Snyder	Address: Snow Hill, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cachexia & Inanition — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: month
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123
DUE TO, OR AS A CONSEQUENCE OF (b): Myocardial & Renal deficiency — year
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from June, 1966, to Apr 12, 1969, that (I) (~~we~~) last saw the ~~deceased~~ alive an Apr 12 1969, and that in (my) (aur) apinian death occurred an the date and haur and fram the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Robert C. La Mar M.D.					4/14/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
ROBERT C. LA MAR M.D.	104 Bay St Snow Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
Burial	4/15/69	Spence Baptist	Snow Hill, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Gerald C. Bounds	Snow Hill, Md.	APR 16 1969	

VR A15 (4)
30M REV. 1/68

1

06193

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06188

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Hazel	Middle:	Last: Simpson	2a. DATE OF DEATH: Month Apr. Day 3 Year 1969	2b. HOUR: M
3. SEX: Female	4. RACE: Negro	5. DATE OF BIRTH: May 8, 1928	6. AGE (In years last birthday): 40 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Worcester Md.		
10. CITY OR TOWN OF DEATH: Pocomoke	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 426 Oxford St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer	12b. KIND OF BUSINESS OR INDUSTRY: Cook		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Worcestr	13c. CITY OR TOWN: Pocomoke	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 426 Oxford St.	
14. FATHER'S NAME First: Randolph	Middle:	Last: Fisher Sr.	15. MOTHER'S MAIDEN NAME First: Naomi	Middle:	Last: Williams
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	16b. SOCIAL SECURITY NO.: 218-20-9035 (If yes give war or dates of service)	17. INFORMANT: Randolph Fisher Sr.	Address: Tampa, Fla.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CVA
DUE TO, OR AS A CONSEQUENCE OF (b): Mural Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (c): Rheumatic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. I **certify** that (I) (this hospital) attended the deceased from 11/69, 19____, to death, 19____, that (I) (~~we~~) last saw the deceased alive on 4/1/69 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22c. DATE SIGNED: 4/7/69

22d. PHYSICIAN'S NAME (Type) 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4-9-69	23c. NAME OF CEMETERY OR CREMATORY: Halls Hill Cem.	23d. LOCATION (City or Town): Pocomoke	(County): Wor. (State): Md.
24. FUNERAL DIRECTOR: [illegible]	ADDRESS: New Church, Va.	25a. REC'D BY REGISTRAR DATE: APR 11 1969	25b. REGISTRAR'S SIGNATURE: [signature]	

VR A15 (4)
30M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medicol Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removol, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06194 — 06189

1. DECEASED-NAME (Type or Print): First ANNA Middle Gertrude Last Weber URY

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ Month Apr Day 20 Year 19 69 — 2b. HOUR 8A M

2c. DATE PRONOUNCED DEAD Month April Day 20 Year 19 69 — 2d. HOUR 9A M

3. SEX: F — 4. RACE: W — 5. DATE OF BIRTH: Sept 24 1903 — 6. AGE (In years last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (State or foreign country): New Jersey — 7b. CITIZEN OF WHAT COUNTRY? U.S.A. — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 9. COUNTY OF DEATH: WORCESTER Md.

10. CITY OR TOWN OF DEATH: Ocean City — 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Bay Shore Drive — 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Post Office Dept — 12b. KIND OF BUSINESS OR INDUSTRY: US Govt.

13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: VA — 13b. COUNTY: Arlington — 13c. CITY OR TOWN: Arlington — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET AND NUMBER: 3424 S. Utah St Arlington VA.

14. FATHER'S NAME: First Fred Middle L. Last Weber — 15. MOTHER'S MAIDEN NAME: First Margaret Middle Hebar Last

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) — 16b. SOCIAL SECURITY NO.: 102-20-2328 — 17. INFORMANT: Mrs. Dorothy Shelton, daughter, — ADDRESS: Arlington, VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Instant

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD + RHD with Hypertension — 5 years

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4100

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 — 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) — 21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: F.S. Townsend Jr. M.D.

EXAMINER'S NAME (Type): F.S. Townsend Jr.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, City, State, or county): Ocean City Md 21842

22b. DATE SIGNED: Apr 20, 69.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE: 4/24/69 — 23c. NAME OF CEMETERY OR CREMATORY: Maple Grove Cemetery — 23d. LOCATION (City or Town) (County) (State): Hakensack, N. J.

24. FUNERAL DIRECTOR: Everly-Wheatley Funeral Home — ADDRESS: Alexandria, Virginia — J.S. Everly

25a. REC'D BY REGISTRAR DATE: APR 24 1969 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 10M REV. 1/68